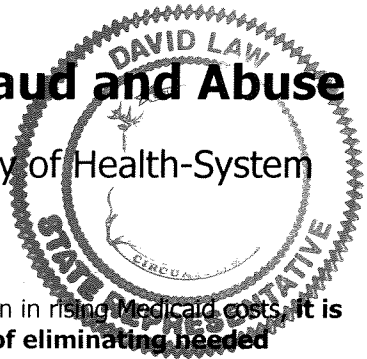
U.S Senate Tackles Medicaid Fraud and Abuse



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WASHINGTON, DC, 13 July 2005 - As Congress explores ways to rein in rising Medicaid costs, **it is imperative that savings to taxpayers not come at the price of eliminating needed programs for the poor but should instead come at the expense of those who have enriched themselves by defrauding the government**, James W. Moorman, president of Taxpayers Against Fraud, told lawmakers in June at a two-day Senate hearing examining Medicaid waste, fraud, and abuse.
Congress has proposed cutting Medicaid's budget by $10 billion over the next five years. However, 74% of Americans surveyed oppose cuts in Medicaid funding, according to a Kaiser Family Foundation poll, which was released the same week that the Senate Finance Committee held its hearing.

Nearly 54 million Americans depend on Medicaid for their health care, according to the Government Accountability Office (GAO), which released two reports in June that criticized the Centers for Medicare and Medicaid Services (CMS) and state Medicaid programs for doing too little to prevent waste and fraud.

CMS has only eight full-time employees dedicated to controlling Medicaid fraud and abuse, according to GAO.

A powerful weapon against fraud. **One of the most effective sources the government has in uncovering complex corporate fraud against Medicaid and returning ill-gotten gains to federal and state treasuries, Moorman said, are whistleblower lawsuits filed under the federal False Claims Act.**

A provision in the law, called Qui Tam, allows persons with evidence of fraud in federal programs or contracts to bring a lawsuit on behalf of the federal government.

Under the provision, whistleblowers are entitled to 15-30% of monies recovered by the federal government in the outcome of a lawsuit.

Medicaid fraud lawsuits filed by whistleblowers against pharmaceutical firms since 2001 have resulted in settlements that have returned $1.2 billion to federal and state coffers, Moorman noted. Recoveries to states and the federal government in lawsuits filed against drug companies involving Medicare and Medicaid fraud total $2.5 billion, he added.

More funding. Even though False Claims Act cases are returning $13 for every $1 invested in litigation, Moorman said, funds and resources allocated to support government investigations into Medicaid fraud and federal lawsuits are insufficient.

He urged Congress to increase funds and resources dedicated to Medicaid fraud investigations and litigation, and he called on states without false claims laws to enact legislation with whistleblower provisions.

"Such a requirement would enable both levels of government to save money on Medicaid without cutting eligibility or benefits or provider reimbursement," Moorman declared.

Because lawsuits filed under the False Claim Act that are not yet settled are sealed and public information about them is unavailable, he said, it is difficult to know exactly how many such cases are currently under investigation by the Department of Justice.

However, Moorman estimated, based on media reports and other information, that there are as many as 250 "cases against drug manufacturers for cheating Medicaid."

Because of the False Claims Act, he said, drug companies are gaining a "much better appreciation" of the importance of full compliance with Medicaid requirements.

Given the volume of medications that Medicaid pays for-the program covered $30 billion for prescription drugs in fiscal year 2004-the "difference between partial and full compliance can literally mean hundreds of millions of dollars in savings to the federal and state governments each year," Moorman said.

Take a bite out of crime. While it is difficult to put an exact dollar figure on the deterrent effect of the False Claims Act, Moorman estimated that it could be worth up to $1.5 billion annually in additional funds to states and the federal government.

He called on Congress to require pharmaceutical firms that do $1 million worth of business annually with Medicaid or Medicare to provide education about the False Claims Act and the Qui Tam provision to company employees.

"If the management of companies that receive significant amounts of money from Medicaid and Medicare were to educate their employees in the workings of the [False Claims Act], they would be far less tempted to devise business plans that involve fraud," Moorman said. "This deterrent effect could save large amounts of money. When employees understand that the submission of false or fraudulent claims to the federal government is against the law, and that violation of the law gives rise to civil liability for their employer, they will be less likely to engage in such conduct or to tolerate such conduct by other employees."

However, he said, he doubts drug companies are eager to support False Claims Act education for employees.

In fact, he said, the pharmaceutical industry has attempted to weaken the False Claims Act and has characterized whistleblowers as "unworthy people" and "bounty hunters" who are vindictive employees.

Marjorie E. Powell, senior assistant general counsel for the Pharmaceutical Research and Manufacturers of America, in testimony before Congress, denied that the pharmaceutical industry had engaged in any tactics to weaken the False Claims Act.

An elaborate plot. Whistleblower Beatrice Manning told lawmakers how her former employer, Schering-Plough, used an "intricate scheme" to conceal from the government the lowest prices, or best prices, the manufacturer was offering private-sector companies for its allergy medication Claritin, which at the time of the infractions was the company's best-selling product and available only by prescription.

Pharmaceutical makers are required by law to report best prices to Medicaid to ensure that the government program is getting the lowest possible price.

Most of Schering-Plough's scheme, she said, was carried out by using the company's wholly owned subsidiary Integrated Therapeutics Group (ITG), "which in retrospect I believe was created specifically to commit fraud."

Manning detailed for the committee how Schering-Plough organized employees' work so that it would be difficult for any one person to figure out the scheme.

"The corporate culture was designed to encourage individuals not to question actions," she said.

Employees who raised concerns that the company was not complying with the federal best-price requirement were subjected to "counseling sessions" with supervisors. Some employees who questioned the firm's activities were terminated, she added.

Although Schering-Plough in July 2004 agreed to plead guilty to violating federal antikickback laws and pay $52.5 million in criminal fines and $290 million to resolve civil liabilities, Manning said, "nobody was held personally responsible for their actions. No executives were pursued either civilly or criminally."

Manning, whom Senator Charles Grassley (R-Iowa), chairman of the Senate Finance Committee, called "a brave woman," split more than $31 million with two other whistleblowers.

"I always advise people against taking action if they are just doing it for the money," she said. "The thought of some potential money some time will not get you through what will in all probability be years of investigation with minimal feedback about what is even going on. Drug companies have major resources to throw at such cases. Over the six years of our case, we estimate that Schering was spending at least $50,000 per day on legal expenses. Individuals, the U.S. Attorney's Office, and private attorneys cannot match that monetary commitment."

Had it not been for the persistence of the attorneys in the U.S. Attorney's Office for the Eastern District of Pennsylvania, Manning said, "I do not believe that this case would have had a successful conclusion."

However, she chastised CMS, calling the agency unhelpful in resolving the case.

Other savings methods. Medicaid could save millions, if not billions, of dollars, government auditors told lawmakers at the hearing, if CMS eliminated the complex pricing system used to reimburse providers for medications for Medicaid beneficiaries and adopted a formula used by Medicare Part B that was mandated under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

MMA changed Medicare's method of reimbursement for prescription drugs from average wholesale price (AWP) to average sales prices (ASP).

AWP, which is used by most states in calculating drug reimbursement amounts, does not reliably reflect the actual prices pharmacies and other providers pay for drugs, said Robert A. Vito, Philadelphia regional inspector general for evaluation and inspections for the Department of Health and Human Services Office of Inspector General (OIG).

The Bush administration in its 2006 budget has proposed adopting ASP for calculating Medicaid reimbursement.

A simple mistake. While some improper billing for Medicaid reimbursement is fraudulent, OIG believes that the vast majority of providers are honest in their billings, said Daniel R. Levinson, the agency's newly appointed inspector general.

Improper billing, he said, may arise because of clerical errors, misinterpretations of rules, or poor record keeping.

Many of the Medicaid fraudulent schemes OIG encounters are similar to ones that mirror schemes in Medicare, such as billing for services not provided, filing false cost reports, and engaging in illegal remunerations or kickbacks.

Billing for services not provided, such as when a provider knowingly bills Medicaid for a treatment or procedure that was not actually performed, is the most common type of fraud committed, Levinson noted.

For fiscal year 2004, he said, OIG conducted joint investigations with state Medicaid Fraud Control Units on 314 criminal cases and 91 civil cases. Of those cases, he added, there were 64 convictions.